

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) before billing Medicaid for the service(s).



Always refer to the long descriptions in coding books.

## Coding

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of *Coding Resources* on the following page. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than unlisted codes. For example, don't use 53899 unlisted procedure of the urinary system when a more specific code is available.
- Bill for the appropriate level of service provided. Evaluation and management services have three to five levels. See your CPT manual for instructions on determining appropriate levels of service.
- CPT codes that are billed based on the amount of time spent with the client must be billed with the code that is closest to the time spent. For example, a provider spends 60 minutes with the client. The code choices are 45 to 50 minutes or 76 to 80 minutes. The provider must bill the code for 45 to 50 minutes.
- Revenue codes 25X and 27X do not require CPT or HCPCS codes; however, providers are advised to place appropriate CPT or HCPCS Level II codes on each line. Providers are paid based on the presence of line item CPT and HCPCS codes. If these codes are omitted, the hospital may be under paid.
- Take care to use the correct "units" measurement. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II billing manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be "each 15 minutes". Always check the long text of the code description published in the CPT-4 or HCPCS Level II coding books. For example, if a physical therapist spends 45 minutes working with a client (97110), and the procedure bills for "each 15 minutes," it would be billed this way:

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
420	Physical Therapy	97110	05/16/03	3	150.00

<b>Coding Resources</b> <b>Please note that the Department does not endorse the products of any particular publisher.</b>		
<b>Resource</b>	<b>Description</b>	<b>Contact</b>
ICD-9-CM	<ul style="list-style-type: none"> <li>• ICD-9-CM diagnosis and procedure codes definitions</li> <li>• Updated each October.</li> </ul>	Available through various publishers and book-stores
CPT-4	<ul style="list-style-type: none"> <li>• CPT-4 codes and definitions</li> <li>• Updated each January</li> </ul>	American Medical Association (800) 621-8335 <a href="http://www.amapress.com">www.amapress.com</a> or Medicode (Ingenix) (800) 765-6588 <a href="http://www.medicode.com">www.medicode.com</a> or <a href="http://www.ingenixonline.com">www.ingenixonline.com</a>
HCPCS Level II	<ul style="list-style-type: none"> <li>• HCPCS Level II codes and definitions</li> <li>• Updated each January and throughout the year</li> </ul>	Available through various publishers and book-stores or from CMS at <a href="http://www.cms.gov">www.cms.gov</a>
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 <a href="http://www.amapress.com">www.amapress.com</a>
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 <a href="http://www.medicode.com">www.medicode.com</a> or <a href="http://www.ingenixonline.com">www.ingenixonline.com</a>
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 <a href="http://www.ntis.gov/product/correct-coding.htm">www.ntis.gov/product/correct-coding.htm</a>
UB-92 National Uniform Billing Data Element Specifications	Montana UB-92 billing instructions	MHA - An Association of Montana Health Care Providers (formerly Montana Hospital Assoc.) Box 5119 Helena, MT 59604 406-442-1911 phone 406-443-3984 fax

## Number of Lines on Claim

Providers are requested to put no more than 40 lines on a UB-92 claim. Although additional lines may be billed on the same claim, the Department claims processing system is most efficient for outpatient claims with 40 lines or fewer.

## Multiple Services on Same Date

Outpatient hospital providers must submit a single claim for all services provided to the same client on the same day. If services are repeated on the same day, use appropriate modifiers.

## Span Bills

Outpatient hospital providers may include services for more than one day on a single claim, so long as the service is paid by fee schedule (e.g., partial hospitalization, therapies, etc.) and the date is shown on the line. However, the OCE (Outpatient Code Editor) will not price APC procedures when more than one date of service appears at the line level, so we recommend billing for only one date at a time when APC services are involved.

## Reporting Service Dates

- All line items must have a valid date of service in form locator (FL) 45.
- The following revenue codes require a separate line for each date of service and a valid CPT or HCPCS Level II code:

Revenue Codes That Require a Separate Line for Each Date of Service and a Valid CPT or HCPCS Code			
26X	IV Therapy	51X	Clinic
28X	Oncology	52X	Free-Standing Clinic
30X	Laboratory	61X	Magnetic Resonance Imaging (MRI)
31X	Laboratory Pathological	63X	Drugs Requiring Specific Identification
32X	Radiology – Diagnostic	70X	Cast Room
33X	Radiology – Therapeutic	72X	Labor Room/Delivery
34X	Nuclear Medicine	73X	Electrocardiogram (EKG/ECG)
35X	Computed Tomographic (CT) Scan	74X	Electroencephalogram (EEG)
36X	Operating Room Services	75X	Gastro-Intestinal Services
38X	Blood	76X	Treatment or Observation Room
39X	Blood Storage and Processing	77X	Preventive Care Services
40X	Other Imaging Services	79X	Lithotripsy
41X	Respiratory Services	82X	Hemodialysis-Outpatient or Home
42X	Physical Therapy	83X	Peritoneal Dialysis-Outpatient or Home
43X	Occupational Therapy	84X	Continuous Ambulatory Peritoneal Dialysis (CAPD)-Outpatient
44X	Speech-Language Pathology	85X	Continuous Cycling Peritoneal Dialysis (CCPD)-Outpatient
45X	Emergency Department	88X	Miscellaneous Dialysis
46X	Pulmonary Function	90X	Psychiatric/Psychological Treatments
47X	Audiology	91X	Psychiatric/Psychological Services
48X	Cardiology	92X	Other Diagnostic Services
49X	Ambulatory Surgical Care	94X	Other Therapeutic Services

## Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4 book, HCPCS Level II book, and other helpful resources (e.g., CPT Assistant, APC Answer Letter and others).
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- Medicaid accepts the same modifiers as Medicare.
- The Medicaid claims processing system recognizes only one modifier. The modifier must be added to the CPT/HCPCS code without a space or hyphen in form locator (FL) 44. For example, 25680 (treatment of wrist fracture) when done bilaterally is reported as 2568050.
- Since the Medicaid claims processing system can read only one modifier per line, it is important to report the most important modifier first. In this case, the most important modifiers for Medicaid are those that affect pricing. Discontinued or reduced service modifiers must be listed before other pricing modifiers. For a list of modifiers that change pricing, see the *How Payment Is Calculated* chapter in this manual.

Hospitals should put the most important modifiers in the first position.

## Billing Tips for Specific Services

Prior authorization is required for some outpatient hospital services. PASSPORT and prior authorization are different, and some services may require both (see the *PASSPORT and Prior Authorization* chapter in this manual). Different codes are issued for each type of approval and must be included on the claim form (see the *Completing A Claim* chapter in this manual).

### **Abortions**

A completed *Medicaid Recipient/Physician Abortion Certification* (MA-37) form must be attached to every abortion claim or payment will be denied (see *Appendix A: Forms*). This is the only form Medicaid accepts for abortions.

### **Drugs and biologicals**

While most drugs are bundled (packaged), there are some items that have a fixed payment amount and some that are designated as transitional pass-through items (see *Pass-through* in the *How Payment Is Calculated* chapter of this manual). Bundled drugs and biologicals have their costs included as part of the service with which they are billed. The following drugs may generate additional payment:

- Vaccines, antigens, and immunizations
- Chemotherapeutic agents and the supported and adjunctive drugs used with them
- Immunosuppressive drugs

- Orphan drugs
- Radiopharmaceuticals
- Certain other drugs, such as those provided in an emergency department for heart attacks

Medicare does not cover revenue code 250 (General class pharmacy). When a client has both Medicare and Medicaid and Medicare denies the pharmacy portion of a claim, providers must report revenue code 250 on a separate UB-92 claim form when submitting the claim to Medicaid.

### ***Lab services***

If all tests that make up an organ or disease organ panel are performed, the panel code should be billed instead of the individual tests.

Some panel codes are made up of the same test or tests performed multiple times. When billing one unit of these panels, bill one line with the panel code and one unit. When billing multiple units of a panel (the same test is performed more than once on the same day), bill the panel code with units corresponding to the number of times the panel was performed.

### ***Outpatient clinic services***

When Medicaid pays a hospital for outpatient clinic or provider based clinic services, the separate CMS-1500 claim for the physician's services must show the hospital as the place of service (i.e., place of service is 22 for hospital outpatient). For imaging and other services that have both technical and professional components, physicians providing services in hospitals must also take care to bill only for the professional component if the hospital will bill Medicaid for the technical component. Refer to the *Physician Related Services* manual, *Billing Procedures* chapter for more information. Manuals are available on the Provider Information website (see *Key Contacts*)

### ***Partial hospitalization***

Partial hospitalization services must be billed with the national code for partial hospitalization, the appropriate modifier, and the prior authorization code.

<b>Current Payment Rates for Partial Hospitalization</b>		
<b>Code</b>	<b>Modifier</b>	<b>Service Level</b>
H0035		Partial hospitalization, sub-acute, half day
H0035	U6	Partial hospitalization, sub-acute, full day
H0035	U7	Partial hospitalization, acute, half day
H0035	U8	Partial hospitalization, acute, full day

**Sterilization**

- For elective sterilizations, a completed *Informed Consent to Sterilization* (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.
- For medically necessary sterilizations (including hysterectomies), one of the following must be attached to the claim, or payment will be denied:
  - A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39) for each provider submitting a claim. See *Appendix A Forms*. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician. Complete only one section (A, B, or C) of this form. When no prior sterility (section B) or life-threatening emergency (section C) exists, the client must sign and date this form at least 30 days prior to the procedure (see 42 CFR 441.250 for the federal policy on hysterectomies and sterilizations). The client does not need to sign this form when sections B or C are used. Please refer to *Appendix A* for more detailed instructions on completing the form.
  - For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
    - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
    - The reason for the hysterectomy was a life-threatening emergency.
    - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

For more information on sterilizations, see the *Covered Services* chapter in this manual.

**Supplies**

Supplies are generally bundled (packaged), so they usually do not need to be billed individually. A few especially expensive supplies are paid separately by Medicaid. Documentation of the Ambulatory Payment Classification (APC) system, available from commercial publishers, lists the supply codes that may be separately payable.